DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11035A (Rev. 06/03)

STATE OF WISCONSIN
HFS 106.03(4), Wis. Admin. Code

WISCONSIN MEDICAID
PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)
COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for dental services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Dental Request Form (PA/DRF) is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with the Prior Authorization/Dental Attachment 1 (PA/DA1) or the Prior Authorization/Dental Attachment 2 (PA/DA2), by fax to Wisconsin Medicaid at (608) 221-8616. This option is available only when the PA request does not include additional documentation, such as models or X-rays. Providers may submit PA requests with attachments by mail to:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — PROVIDER INFORMATION

Element 1 — Name and Address — Billing Provider
Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

Element 2 — Telephone Number — Billing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 3 — Processing Type
Check the appropriate box to indicate the processing type for either dental services (124) or orthodontic services (125).

Element 4 — Billing Provider's Medicaid Provider No.
Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must correspond with the provider name listed in Element 1.

Element 5 — Performing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the performing provider, if it is different from the number in Element 4. This is the provider who will actually perform the service.

SECTION II — RECIPIENT INFORMATION

Element 6 — Recipient Medicaid ID Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

Element 7 — Date of Birth — Recipient
Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1966, would be 09/08/66).

Element 8 — Address — Recipient
Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

Element 9 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 10 — Sex — Recipient
Enter an "X" in the appropriate box to specify male or female.

SECTION III — DIAGNOSIS / TREATMENT INFORMATION

Element 11 — Place of Service
Check the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/ dispensed.

Element 12 — Dental Diagram
For partials, endodontics, and periodontics, circle the periodontal case type. On the dental diagram, cross out ("X") missing teeth (including extractions). Circle teeth to be extracted only when requesting endodontic or partial denture services. At the bottom of the element, indicate the number and type of X-rays submitted with this PA request. Staple the X-ray envelope to the PA/DRF to the right of Element 12.

Element 13 — Tooth No.
Using the numbers and letters on the dental diagram in Element 12, identify the tooth number or letter for the service requested.

Element 14 — Procedure Code
Enter the appropriate procedure code for each service/procedure/item requested.

Element 15 — Modifier
Enter the modifier corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

Element 16 — Description of Service
Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

Element 17 — QR
Enter the appropriate quantity requested (e.g., number of services) for each procedure code listed.

Element 18 — Charge
Enter the usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1.0," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

Note: The charges indicated on the PA/DRF should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

Element 19 — Total Charges
Enter the anticipated total charge for this request.

Element 20 — Signature — Performing Provider
The original signature of the provider requesting this service/procedure must appear in this element.

Element 21 — Date Signed
Enter the month, day, and year the PA/DRF was signed (in MM/DD/YY format).

Element 22 — Signature — Recipient / Guardian (if applicable)
If desired, the recipient or recipient's guardian may sign the PA request.

Element 23 — Date Signed
Enter the month, day, and year the recipient or recipient's guardian signed the PA request.

Detach and keep the bottom copy of the PA/DRF. Leave the top two forms attached.

Provider checklist: *The bottom copy of the PA/DRF features a provider checklist to assist with requests for periodontics, endodontics, and services requiring enclosures. For additional information, consult the Dental Provider Handbook.*